TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION  TO. REGIONAL ADMINISTRATION  DEPARTMENT OF HEALTH AND HUMAN SERVICES  TYPE OF PLAN MATERIAL (PACK One):    NEW STATE PLAN	DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION		FORM APPROVED OMB NO. 0938-0193
STATE PLAN MATERIAL  FOR: HEALTH CARE FINANCING ADMINISTRATION  TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION  DEPARTMENT OF HEALTH AND HUMAN SERVICES  STYPE OF PLAN MATERIAL (Check One):    NEW STATE PLAN	•		2. STATE:
STATE PLAN MATERIAL  FOR: HEALTH CARE FINANCING ADMINISTRATION  TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES  5. TYPE OF PLAN MATERIAL (Check One):    NEW STATE PLAN   AMENDMENT TO BE CONSIDERED AS NEW PLAN   SI AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)  6. FEDERAL STATUTE-REGULATION CITATION: 42 CPR 435.232   PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 6 to Attachment 2.6-A, pages 2 thru 4  2. Supplement 6 to Attachment 2.6-A, pages 2 thru 4  10. SUBJECT OF AMENDMENT: Revises the methodology for calculating the standards for optional state supplementary payments.  11. GOVERNOR'S REVIEW (Check One):   Governor's Office Reported No Comment   Others of Governor's Office Enclosed   No Reply Received Within 45 Days of Submittal.  12. SIGNATURE OF STATE AGENCY OFFICIAL:   June 24. 2002   The Plan Section of State Office Bailding Des Moines, IA 50319-0114  15. DATE SUBMITTED:   June 24. 2002   The Plan Section of State Office Bailding Des Moines, IA 50319-0114  16. RETURN TO:   Director   Di	TRANSMITTAL AND NOTICE OF APPROVAL OF	$\frac{0}{2} - \frac{0}{0} \cdot \frac{0}{8}$	Towa
TO. REGIONAL ADMINISTRATOR HEALTH CARE FRANCING ADMINISTRATION OF PARTMENT OF HEALTH AND HUMAN SERVICES  TYPE OF PLAN MATERIAL (PLOKE Of One):    NEW STATE PLAN		3. PROGRAM IDENTIFICATION: TITL	
HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES  5. TYPE OF PLAN MATERIAL (Check One):    NEW STATE PLAN	FOR: HEALTH CARE FINANCING ADMINISTRATION	SECURITY ACT (MEDICAID)	
DEPARTMENT OF HEALTH AND HUMAN SERVICES  5. TYPE OF PLAN MATERIAL (Check One):    New STATE PLAN   AMENDMENT TO BE CONSIDERED AS NEW PLAN   AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)  6. FEDERAL STATUTE-REGULATION CITATION:   42 CTR 435,232   5		4. PROPOSED EFFECTIVE DATE	
NEW STATE PLAN		June 1, 2002	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)  6. FEDERAL STATUTE/REGULATION CITATION:  42 CPR 435.232  8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 6 to Attachment 2.6-A, pages 2  thru 4  9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: Supplement 6 to Attachment 2.6-A, pages 2  thru 4  10. SUBJECT OF AMENDMENT:  Revises the methodology for calculating the standards for optional state supplementary payments.  11. GOVERNORS REVIEW (Check One):  12. GOVERNORS REVIEW (Check One):  13. TYPED NAME:  13. TYPED NAME:  14. TITLE:  15. DATE SUBMITTED:  16. RETURN TO:  17. DATE ACCIVED WITHIN 45 DAYS OF SUBMITTAL  16. RETURN TO:  17. DATE ACCIVED WITHIN 45 DAYS OF SUBMITTAL  16. RETURN TO:  17. DATE ACCIVED WITHIN 45 DAYS OF SUBMITTAL  16. RETURN TO:  17. DATE ACCIVED WITHIN 45 DAYS OF SUBMITTAL  16. RETURN TO:  17. DATE ACCIVED WITHIN 45 DAYS OF SUBMITTAL  16. RETURN TO:  17. DATE ACCIVED WITHIN 45 DAYS OF SUBMITTAL  16. RETURN TO:  17. DATE ACCIVED WITHIN 45 DAYS OF SUBMITTAL  16. RETURN TO:  17. DATE ACCIVED WITHIN 45 DAYS OF SUBMITTAL  16. RETURN TO:  17. DATE ACCIVED WITHIN 45 DAYS OF SUBMITTAL  18. RETURN TO:  19. PAGE NUMBER OF THE SUPPERSEDED PLAN EXCITON OR ATTACHMENT (# Apple Submitted Plan Accived Submitted Plan A	5. TYPE OF PLAN MATERIAL (Check One):		
6. FEDERAL STATUTE/REGULATION CITATION:  42 CPR 435,232  8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Supplement 6 to Attachment 2.6-A, pages 2 thru 4  Supplement 6 to Attachment 2.6-A, pages 2 thru 4  Our (9 2 - 08)  9. PAGE NUMBER OF THE SUPERSEED PLAN SECTION OR ATTACHMENT!  Supplement 6 to Attachment 2.6-A, pages 2 thru 4  Our (9 2 - 08)  10. SUBJECT OF AMENDMENT:  Revises the methodology for calculating the standards for optional state supplementary payments.  11. GOVERNORS REVIEW (Check One):  12. GOVERNORS REVIEW (Check One):  13. TYPED NAME:  14. ITILE:  15. DATE SUBMITTED:  17. TATE HOSTED:  27. THE TABLE HOSTED:  28. THE TABLE HOSTED:  29. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  29. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  20. SUBJECT OF AMENDMENT:  16. RETURN TO:  Director  Department of Bluman Services  Hoover State Office Building  Des Hoines, IA 50319-0114  17. TATE HOSTED:  29. THE:  Thomas N. Lenz  20. FEARNES:  Pages 2 thru 4  OUR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A,  pages 2 thru 4  OUR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A,  pages 2 thru 4  OUR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A,  pages 2 thru 4  OUR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A,  pages 2 thru 4  OUR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A,  pages 2 thru 4  OUR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A,  pages 2 thru 4  OUR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A,  pages 2 thru 4  OUR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A,  pages 2 thru 4  OUR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A,  pages 2 thru 4  OUR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A,  pages 2 thru 4  OUR AT	☐ NEW STATE PLAN ☐ AMENDMENT TO BE COM	NSIDERED AS NEW PLAN [] A	MENDMENT
a. FFY 02 \$ 0   b. FFY 03 \$ 0	COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMEN	DMENT (Separate Transmittal for each ame	endment)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 6 to Attachment 2.6-A, pages 2 thru 4  9. PAGE NUMBER OF THE SUPPRSEDED PLAN SECTION OR ATTACHMENT: Supplement 6 to Attachment 2.6-A, pages 2 thru 4  10. SUBJECT OF AMENDMENT:  Revises the methodology for calculating the standards for optional state supplementary payments.  11. GOVERNORS REVIEW (Check One):  12. SIGNATURE OF STATE AGENCY OFFICIAL:  13. TYPED NAME:  Jessie K. Rasmussen  14. ITILE:  Director  15. DATE SUBMITTED:  Inc. 24. 2002  17. DATE SUBMITTED:  Inc. 24. 2002  20. TITLE:  ARA for Medicaid State Operations	6. FEDERAL STATUTE/REGULATION CITATION:		
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 6 to Attachment 2.6-A, pages 2 thru 4  10. SUBJECT OF AMENDMENT: Revises the methodology for calculating the standards for optional state supplementary payments.  11. GOVERNORS REVIEW (Check One):	40 000 405 000		<del></del>
OR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A, pages 2 thru 4  Jour (p - Jos)  10. SUBJECT OF AMENDMENT:  Revises the methodology for calculating the standards for optional state supplementary payments.  11. GOVERNORS REVIEW (Check One):  GOVERNORS OFFICE REPORTED NO COMMENT  GOVERNORS OFFICE REPORTED NO COMMENT  GOVERNORS OFFICE REPORTED NO COMMENT  OR ATTACHMENT (# Applicable):  Supplement 6 to Attachment 2.6-A, pages 2 thru 4  JOUR (p - Jos)  10. SUBJECT OF AMENDMENT:  GOVERNORS REVIEW (Check One):  GOVERNORS REVIEW (Check One):  GOVERNORS OFFICE REPORTED NO COMMENT  GOVERNORS REVIEW (Check One):  GOVERNORS			DED PLAN SECTION
Supplement 6 to Attachment 2.6-A, pages 2 thru 4			DED I DAN SCOTION
pages 2 thru 4	• • • •	Supplement 6 to Attachmen	nt 2.6-A.
10. SUBJECT OF AMENDMENT:  Revises the methodology for calculating the standards for optional state supplementary payments.  11. GOVERNOR'S REVIEW (Check One):  12. GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  12. SIGNATURE OF STATE AGENCY OFFICIAL:  13. TYPED NAME:  14. TITLE:  15. DATE SUBMITTED:  17. DATE FLOTING OF APPROVED MATERIAL:  16. RETURN TO:  17. DATE OF STATE AGENCY OFFICIAL:  18. DIRECTOR  19. DATE SUBMITTED:  19. DATE OF STATE AGENCY OFFICIAL:  19. DATE OF STATE AGENCY OFFICIAL:  10. DIRECTOR  10. DIRECTOR  10. DIRECTOR  10. DIRECTOR  10. DIRECTOR  10. DATE OF MAIN SERVICES  10. DOWNER OF STATE AGENCY OF INCIDENT OF A STATE AGENCY		1	
Revises the methodology for calculating the standards for optional state supplementary payments.  11. GOVERNORS REVIEW (Check One):    GOVERNORS OFFICE REPORTED NO COMMENT   OTHER, AS SPECIFIED:   COMMENTS OF GOVERNORS OFFICE ENCLOSED   NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  12. SIGNATURE OF STATE AGENCY OFFICIAL:   Director   Dire		Lour	(92-008)
Revises the methodology for calculating the standards for optional state supplementary payments.  11. GOVERNORS REVIEW (Check One):    GOVERNORS OFFICE REPORTED NO COMMENT   OTHER, AS SPECIFIED:   COMMENTS OF GOVERNORS OFFICE ENCLOSED   NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  12. SIGNATURE OF STATE AGENCY OFFICIAL:   Director   Dire		willy	d. 09/09/02
Revises the methodology for calculating the standards for optional state supplementary payments.  11. GOVERNORS REVIEW (Check One):    GOVERNORS OFFICE REPORTED NO COMMENT   OTHER, AS SPECIFIED:   COMMENTS OF GOVERNORS OFFICE ENCLOSED   NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  12. SIGNATURE OF STATE AGENCY OFFICIAL:   Director   Dire	A OUR FOT OF MENTALENT	theel	ue: 06/01/0
payments.  11. GOVERNOR'S REVIEW (Check One):    GOVERNOR'S OFFICE REPORTED NO COMMENT   OTHER, AS SPECIFIED:    COMMENTS OF GOVERNOR'S OFFICE ENCLOSED   NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  12. SIGNATURE OF STATE AGENCY OFFICIAL:   Jessie K. Rasmussen   Director   Department of Human Services   Hoover State Office Building   Des Hoines, IA 50319-0114    14. TITLE:   Director   Department of Human Services   Hoover State Office Building   Des Hoines, IA 50319-0114    15. DATE SUBMITTED:   The 24, 2002   FORGE COALS   C	10. SUBJECT OF AMENDMENT:	• •	,
GOVERNORS OFFICE REPORTED NO COMMENT  COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  12. SIGNATURE OF STATE AGENCY OFFICIAL:  13. TYPED NAME:  Jessie K. Rassussen  14. TITLE:  Director  15. DATE SUBMITTED:  JUN 0 1 2002  FOR RECOINS  CERTIFICATION OF APPROVED MATERIAL:  JIN 0 1 2002  21. TYPED NAME:  Thomas W. Lenz  22. TITLE:  ARA for Medicaid State Operations	52	andards for optional state s	upplementary
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  12. SIGNATURE OF STATE AGENCY OFFICIAL:  13. TYPED NAME:  Jessie K. Rasmussen  14. TITLE:  Director  15. DATE SUBMITTED:  JUNE 24. 2002  FORTIES CHARGE  PERMANCE:  PERMANCE:  ARA for Medicaid A. State Operations  ARS TO Medicaid A. State Operations  Descriptions  Description of Medicaid A. State Operations  Description of Medicaid A. State	11. GOVERNOR'S REVIEW (Check One):		
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  12. SIGNATURE OF STATE AGENCY OFFICIAL:  13. TYPED NAME:  Jessie K. Rasmussen  14. TITLE:  Director  15. DATE SUBMITTED:  JUNE 24 2002  FORTIES DIALES  PLANTIFIC OF APPROVED MATERIAL:  16. RETURN TO:  Director  Department of Human Services Hoover State Office Building Des Moines, IA 50319-0114  PARTIFIC OFFICE DIALES  TOTAL SUBMITTED:  JUNE 24 2002  PLANTIFIC OFFICE OF APPROVED MATERIAL:  JUN 01 2002  21. TYPED NAME:  Thomas W. Lenz  ARA for Medicaid A State Operations  ASSUISSEN  ASSUISSEN  ASSUISSEN  Description of Human Services Hoover State Office Building Des Moines, IA 50319-0114  16. RETURN TO:  Director  Department of Human Services Hoover State Office Building Des Moines, IA 50319-0114  22. TITLE:  ARA for Medicaid A State Operations  ASSUISSEN  ASSUISSEN  DESCRIPTION OF Medicaid A State Operations Description of Medicaid A State Operation of Medicaid A State Operatio	GOVERNOR'S OFFICE REPORTED NO COMMENT	OTHER, AS SPECIFIED:	ali dhi kuralikua
In the state of state agency of submittal  12. Signature of state agency of scale  13. Typed Name:  Jessie K. Rasmussen  14. Title:  Director  15. Date submitted:  Jine 24. 2002  FORRES CALO  17. Date submitted:  JUNE 12. OR  PERNAUD AGE  17. Date of Approved Naternal  18. Return to:  Director  Department of Human Services  Hoover State Office Building  Des Moines, IA 50319-0114  Des Moines, IA 5	·	•	
Director  13. TYPED NAME:  Jessie K. Rasmussen  14. ITHE:  Director  15. DATE SUBMITTED:  Three 24, 2002  FOR IESO (ALC)  CONTEST OF APPROVED NATE HAVE BEEN BEEN BEEN BEEN BEEN BEEN BEEN BE			
Director  13. TYPED NAME:  Jessie K. Rasmussen  14. ITHE:  Director  15. DATE SUBMITTED:  Three 24, 2002  FOR IESO (ALC)  CONTEST OF APPROVED NATE HAVE BEEN BEEN BEEN BEEN BEEN BEEN BEEN BE	12. SIGNATURE OF STATE AGENCY OF FICIAL:	IS RETURN TO:	
13. TYPED NAME:  Jessie K. Rasmussen  14. TITLE:  Director  15. DATE SUBMITTED:  June 24, 2002  FORRIES NATO  DEPARTMENT OF HUMAN Services  Hoover State Office Building Des Moines, IA 50319-0114  DES MOINES, IA	Linex Kanum		
Jessie K. Rasmussen  14. TITLE:     Director  15. DATE SUBMITTED:     June 24. 2002  FORRIES MATO  16. Effective Date of Approved Material:     JUN 01 2002  21. TYPED NAME:     Thomas W. Lenz  22. TITLE:     ARA for Medicaid & State Operations     Rasmussen  Applications  SPA CONTROL  Applications  Applicatio	13. TYPED NAME:		·
Director  15. DATE SUBMITTED:  June 24, 2002  FORRESOLATOR CO.  17. DATE REGENTED  10. ZOVIZ  PPRANSPHRYED  10. ZOVIZ  PPRANSPHRYED  22. TITLE:  Thomas W. Lenz  23. REMARKS:  24. ZOVIZ  24. TYPED NAME:  RASHISSEN  PARENTS:  PA	Jessie K. Rasmussen		
15. DATE SUBMITTED:  JUNE 24. 2002  FORRIES STATE  15. DATE SUBMITTED:  16. DATE SUBMITTED:	· - ·	Des Moines, IA 50319-0114	our esta esta esta esta esta esta esta esta
FORRESONAL SEASONAL S			
PANAPHOVED  17 DATE (FORMED)  10 /20 / 12  PANAPHOVED - (FIRE SOLVE)  10 / 20 / 12  10 / 20 / 12  21. TYPED NAME:  Thomas W. Lenz  22. TITLE:  ARA for Medicaid in State Operations  Rasmissen  Analogous  Assentata		A AMORTAN TO LOUGH CO.	
DESTRICTIVE DATE OF APPROVED WATERIAL.  JUN 01 2002  21. TYPED NAME:  Thomas W. Lenz  ARA for Medicaid & State Operations  Reserved to be such entroised and resist from layonese pallocal dates and resist fr	FOR REGIONAL OF	Commence	en e
DESTRUCTIVE DATE OF APPROVED MATERIAL  JUN 0 1 2002  21. TYPED NAME:  Thomas W. Lenz  22. TITLE:  ARA for Medicaid in State Operations  Rasmissen  Appletson  Applets			
DIN 01 2002  21. TYPED NAME: Thomas W. Lenz  ARA for Medicaid & State Operations  SPA CONTRO  Rasmissen Anderson  Of 21/02  ARA For Medicaid & State Operations  SPA CONTRO  Batter State Of 21/02  ARA FOR Medicaid & State Operations  SPA CONTRO  Batter State Of 21/02  ARA FOR Medicaid & State Operations  SPA CONTRO  Batter State Of 21/02  ARA FOR Medicaid & State Operations  SPA CONTRO  Batter State Of 21/02  ARA FOR Medicaid & State Operations  SPA CONTRO  Batter State Of 21/02  ARA FOR Medicaid & State Operations  SPA CONTRO  Batter State Of 21/02  ARA FOR Medicaid & State Operations  SPA CONTRO  Batter State Of 21/02  ARA FOR Medicaid & State Operations  SPA CONTRO  Batter State Operations  SPA CONTRO  Batter State Operations  ARA FOR Medicaid & State Operations  SPA CONTRO  Batter State Operations  Batter State Operations  SPA CONTRO  Batter State		発達などという。	The British of the State of the
21. TYPED NAME: Thomas W. Lenz  22. TITLE: ARA for Medicaid & State Operations  23. REMARKS: SPA CONTROL Results on the process of the proces	我们的时候,一直就是这种的时候,我们就是一个人的时候,我们就是一个人的时候,我们就是这个人的时候,这个人的时候,这个人的一个人的一个人的一个人的一个人的一个人的		
21. TYPED NAME: Thomas W. Lenz  22. TITLE: ARA for Medicaid & State Operations  23. REMARKS: SACCOURDS RESERVISSES	The state of the s		
Thomas W. Lenz  23. REMARKS:  SPA CONTROL  Respulses to the process of the second of t		22 TILE:	age spec
23. REMARKS:  SECRETARY OF EACH PROCESS OF A CONTROL OF A			cations . and one work
Rasmissen  Anderson  On State of the Control of the			A PARTY
Appletson 1 Control of the Control o	professional particular escape and acceptance	AND THE PROPERTY OF THE PARTY O	
	And Son	Date Received: 3 06/26/02	
	CO.		
	AND IN I AMERICAN AND ADDRESS OF THE PARTY O		

Revision: HCFA-AT-	85-3		SUPPLEMENT 6 TO
February 1985			ATTACHMENT 2.6-A
•	State	Iowa	Page 2

## STANDARDS FOR OPTIONAL STATE SUPPLEMENTARY PAYMENTS

Note: The "dependent person maximum benefit amount" is set by determining the amount needed to meet the maintenance of effort requirement, based on the Social Security cost-of-living adjustment percentage.

- A. This income level is equal to the SSI maximum benefit for one person plus the blind supplement amount for one person plus the Social Security income disregard.
- B. This net income level is equal to the SSI maximum benefit for one person plus the blind supplement amount for one person.
- C. This gross income level is equal to the SSI maximum benefit for a couple plus the blind supplement amount for a couple plus the Social Security income disregard.
- D. This net income level is equal to the SSI maximum benefit for a couple plus the blind supplement amount for a couple.
- E. This gross income level is equal to the SSI maximum benefit for a couple plus the blind supplement amount for one person plus the Social Security income disregard.
- F. This net income level is equal to the SSI maximum benefit for a couple plus the blind supplement amount for one person.
- G. This gross income level is equal to the SSI maximum benefit for one person plus the dependent person maximum benefit amount plus the Social Security income disregard.
- H. This gross income level is equal to the SSI maximum benefit for a couple plus the dependent person maximum benefit amount plus the Social Security income disregard.
- I. This net income level is equal to the SSI maximum benefit for one person plus the dependent person maximum benefit amount.
- J. This net income level is equal to the SSI maximum benefit for a couple plus the dependent person maximum benefit amount.
- K. This gross income level is equal to the SSI maximum benefit for one person plus the dependent person maximum benefit amount plus the blind supplement amount for one person plus the Social Security income disregard.

TN No.	MS-02-8	ecp 0 a 2002 JUN 0 1 2	กกว
Supersedes TN No.	MS-01-09	Approval Date SEP 0 9 2002 Effective Date 0 1 2	

	State	<u>Iowa</u>	Page 3
February 1985			ATTACHMENT 2.6-A
Revision: HCFA-AT-	-85-3		SUPPLEMENT 6 TO

## STANDARDS FOR OPTIONAL STATE SUPPLEMENTARY PAYMENTS

- L. This net income level is equal to the SSI maximum benefit for one person plus the dependent person maximum benefit amount plus the blind supplement amount for one person.
- M. This gross income level is equal to the SSI maximum benefit for a couple plus the dependent person maximum benefit amount plus the blind supplement amount for a couple plus the Social Security income disregard.
- N. This net income level is equal to the SSI maximum benefit for a couple plus the dependent person maximum benefit amount plus the blind supplement amount for a couple.
- O. This gross income level is equal to the SSI maximum benefit for a couple plus the dependent person maximum benefit amount plus the blind supplement amount for one person plus the Social Security income disregard.
- P. This net income level is equal to the SSI maximum benefit for a couple plus the dependent person maximum benefit amount plus the blind supplement amount for one person.
- Q. This gross income level is equal to the SSI maximum benefit for one person plus the maximum family-life home payment. The maximum family-life home payment is set by determining the amount needed to meet the maintenance of effort requirement, based on the Social Security cost-of-living adjustment percentage.
- R. This net income level is equal to the SSI maximum benefit for one person plus the maximum family-life home payment. The maximum family-life home payment is set by determining the amount needed to meet the maintenance of effort requirement, based on the Social Security cost-of-living adjustment percentage.
- S. This income level is the per diem rate of the facility subject to a maximum of 31 x the maximum rate (set by determining the amount needed to meet the maintenance of effort requirement based on the Social Security cost-of-living adjustment percentage) plus the personal needs allowance.

The personal needs allowance is increased at the same time and by the same percentage as any cost of living increase to SSI and Social Security plus the current statewide monthly average per month copayment amount for people receiving State Supplementary assistance as calculated once a year.

TN No.	MS-02-8	QED A Q 2002 #IN A 4	วกกว
Supersedes TN No.	MS-01-09	Approval Date P 0 9 2002 Effective Date UN 0 1	<u> Zuuz</u>

	sion: HCFA-AT-85-3 uary 1985 StateIowa	SUPPLEMENT 6 TO ATTACHMENT 2.6-A Page 4
	STANDARDS FOR OPTIONAL STATE SUPPLEME	NIARY PAYMENIS
T.	This gross income level is equal to the SSI maximum benefinaximum monthly reimbursement rate for in-home health-rate amount needed to meet the maintenance of effort require Security cost-of-living adjustment percentage).	related care (set by determining
U.	This gross income level is equal to the SSI maximum benefit maximum monthly reimbursement rate for in-home health-the amount needed to meet the maintenance of effort require Security cost-of-living adjustment percentage).	related care (set by determining
V.	This net income level is equal to the SSI maximum benefit the maximum monthly reimbursement rate for in-home head determining the amount needed to meet the maintenance of Social Security cost-of-living adjustment percentage).	Ith-related care (set by
W.	This net income level is equal to the SSI maximum benefit monthly reimbursement rate for in-home health-related care needed to meet the maintenance of effort requirement based living adjustment percentage).	(set by determining the amount
Χ.	This gross income level is equal to the SSI maximum benefit maximum monthly reimbursement rate for in-home health-the amount needed to meet the maintenance of effort require Security cost-of-living adjustment percentage).	related care (set by determining
Y.	This net income level is equal to the SSI maximum benefit monthly reimbursement rate for in-home health-related care needed to meet the maintenance of effort requirement based living adjustment percentage).	e (set by determining the amount

TN No.

TN No. MS-02-8 Supersedes TN No. MS-01-09

SEP 0 9 2002

Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_ 5002